SECTION 1

Building the Foundation for Selecting and Applying Community and Public Health Education Methods and Strategies

CHAPTER 1 Laying the Foundation for Selecting Community and Public Health Education Methods and Strategies 3

CHAPTER 2 Becoming a Health Education Professional. 17

CHAPTER 3 Promoting Health Education in a Multicultural Society 43

CHAPTER 4 Applying a Health Literacy Framework. 67

CHAPTER 1

Laying the Foundation for Selecting Community and Public Health Education Methods and Strategies

Jodi Brookins-Fisher, PhD, MCHES®, FESG
Robert J. Bensley, PhD, MCHES®

Author Comments

This chapter introduces the reader to foundations underlining why we select the methods and strategies we do for implementing health education programs. The role of health education specialists is to understand the underlying causes, or determinants, of negative health behaviors and outcomes and how to select methods and strategies that are most likely to motivate and educate individuals, families, organizations, and communities. Through training, health education specialists are equipped with skills and empowered to change environments and behaviors to improve the quality and quantity of people's lives. The existence of this power to make a difference creates the burden of responsibility to practice theoretically sound health education. How can health education specialists, then, implement health education with some assurance that specific health problems are being addressed in the best possible way? By focusing on the real determinants impacting health and following appropriate theory when selecting and applying methods that will yield positive results.

CHES COMPETENCIES

8.1.5 Use evidence-informed theories, models, and strategies.

Data from National Commission for Health Education Credentialing, Inc. (NCHEC) and the Society for Public Health Education (SOPHE).

Introduction

Health education specialists cannot assume or take for granted that everyone is motivated and learns the same. There is no generic way to educate about health. If there were, there would be no use for this book. One of the most difficult tasks for behavioral scientists and health education specialists is changing and sustaining individual or group behavior. At the same time, it is important to understand how behavior fits into a broader social ecological model, where focus is on not only individual behavior change but also interpersonal, organizational, community, and policy change. This model affirms the importance of using multipronged approaches when attempting to change and sustain behaviors, and it is through this broader intervention perspective that the greatest likelihood for influential change on the individual can occur.

Selection of health education methods needs to consider the focus of influence, or what level the intervention is geared toward. Central to the application of the social ecological model is that health status and behaviors are shaped by various levels of influence, following a macro- to micro-level approach, where broader spheres of influence have the capability to reach and support greater change in health status or behavior.[1] This model can be visualized as a series of concentric circles, with the innermost circle focusing on intrapersonal factors associated with the individual. At this level, efforts are made to influence the individual in adopting specific positive health behaviors. These behaviors can then be supported or encouraged through interpersonal relationships via family, social groups, or other social networks. Organizational structures, such as health and medical plans, population health–serving organizations, and the like, provide mechanisms for ensuring individual ability to engage in and sustain behaviors. Community-level influence coming from employers, media, community-based organizations, businesses, and other community structures assists in providing a broader level of support for engaging in and maintaining positive behavior changes. At the broadest end, policy initiatives such as laws, policies and regulations, health prevention strategies and goals, and state or national guidelines drive the focus on ensuring whatever positive behaviors are being sought can thrive. Each level has influence on the circles contained within it, so that the widest net is cast at the furthermost circle (i.e., policy level), which has great influence on community and organization, which has influence on interpersonal, and so forth (**FIGURE 1.1**).

When considering how best to impact individual change, then, it is important to consider which strategies and methods will have the greatest likelihood of ensuring that change can be sustained. Along with the need for individual change, a good health education specialist will

FIGURE 1.1 Social Ecological Model

also try to effect change in the social determinants of health within the individual's broader environment. As previously stated, this might include instituting methods for change in a policy or community. Method selection, therefore, is broadly defined, and different methods work in different situations for different groups. A "one method fits all" does not exist, and there is rarely a singular method for behavioral or environmental change to occur.

Planning models are helpful to health education specialists because they not only map out which methods are appropriate considering the individual, program, and environment but ensure method selection occurs only after program goals and objectives have been developed. It is always exciting to get to the method selection; however, it is of utmost importance that methods are selected based on the program's desired outcomes. Otherwise, it is difficult to determine if and when change occurs. As always, scientifically based research should be consulted to help determine which methods have been tested and show the best possibility of success.

This book is a collection of different methods that can be used at various levels to impact the greatest likelihood of success with positive health. Each chapter is designed to present different

COMMUNITY CONNECTIONS 1.1

Jacque has 10 years of experience working in public health, six of which were as a registered dietitian working in the Women, Infants, and Children (WIC) program and the last four as supervisor of the maternal and infant section of the Central District Health Department. She received a master's degree in health education and is very active in the state's chapter of the Society for Public Health Education (SOPHE), serving as its president. As a supervisor, she is highly organized and considered a "pro" by her peers.

Nadia is a graduate of a respected undergraduate public health education program and recently received CHES status. She has been employed by the health department for one and a half years and is considering starting on her master's degree in public health education at a nearby university. Her colleagues know her as a creative person with a solid understanding of professional issues. Like many health education specialists, she tries to balance her commitments and responsibilities to her family, employment, and potential graduate studies.

Max is a recent graduate with a bachelor's degree in public health education from one of the state's universities known for its excellent professional preparation program. As an undergraduate, he was active in Eta Sigma Gamma, the National Health Education Honorary, serving as chapter president. Max was hired six months ago as a health education specialist, where he shares time between the maternal and infant, chronic disease, and health promotion and community assessment sections of the department.

If you ask Nadia, with her one and a half years' experience, she will tell you that at times she becomes frustrated and disappointed with the lack of success in motivating individuals to make changes in their health behaviors. She often feels disillusioned with her chosen profession. As an undergraduate, she believed she could make a difference in people's lives by helping them live healthy lifestyles. At times there seems to be progress toward this belief, which gives her hope.

Jacque can identify with Nadia's disillusionment because she went through a similar experience as a dietitian. It was after attending a state SOPHE conference and starting her master's degree that she realized there was more to improving population health than just one-on-one transference of content, knowledge, and behavior change skills. As a dietitian, Jacque had integrated her personal strengths, such as her organizational and communication skills, into her practice at the expense of applying theory to the selection of methods. She could see where Nadia, like herself, would use motivational and behavioral change methods without a sound theoretical foundation. Jacque knows that Nadia needs help and encouragement as well as guidance in applying theory within a social ecology framework.

Max, on the other hand, is doing all he can to make health education work. Like many young professionals, he and Nadia are hardworking, enthusiastic, and idealistic in their pursuits. Being spread across sections, though, he has much to learn.

models and methods that can be used within interventions designed to influence change. The remainder of this chapter focuses on an introduction to change theory—the backbone necessary for implementing any of the methods appearing in this book.

Health Education Theories

Methods selected by health education specialists should be grounded in behavior change theory. The health education profession has subscribed to a number of theories, which take into consideration variables that influence individual behavior and population health. These theories serve as a foundation and structure from which public health education methods can be applied. Selecting methods without considering theory is like building a house without a foundation. The potential for the house to collapse will always be a threat. Likewise, methods chosen without a theoretical base will be vulnerable to failure. Can health education specialists afford to take these risks? Of course not—health education specialists are concerned about individual lifestyles and community structural issues that cause real or potential health problems. As a result, programs with the greatest potential for success must be designed and implemented. The understanding and application of theory to practice form an insurance policy that this will occur.

It is important to understand the meaning of theory. A **theory** is a general explanation of why people act or do not act to maintain and/or promote the health of themselves and their families, organizations, and communities.[2] There are numerous theories commonly used by health education specialists. It is the intent of this chapter not to explain all the theories in health education but to discuss a limited number—those commonly used. Unfortunately, theories do not work in some situations, which is why researchers and theorists are constantly trying to improve and develop new theories and models. In time, new theories will evolve that will continue to help better explain the most effective approaches for effecting change in individuals and communities.

Within the context of behavior change, theories can generally be classified in two groups, depending on their focus. Intrapersonal theories focus on individuals as the units of change, whereas interpersonal and community theories focus on social systems, organizations, and cultures. Intrapersonal theories are based on the premises that behavior is determined by (1) what we know, which, in turn, results in how we act; and (2) perceptions, attitudes, beliefs, levels of motivation, self-efficacy, skills, resiliency, and environmental variables. Interpersonal and community models are designed to support healthy lifestyles by reducing or eliminating hazards in social and physical environments. These models center on community-level change, including community organization, theories of organizational change, and diffusion of innovation, and are important in planning comprehensive community-based programs.

Although there are numerous theories and models that have been used to promote individual and population health changes, three intrapersonal- and two interpersonal-focused theories and models are commonly used by health education specialists. The following section contains a simple description of each theory and its practical application, as displayed in the ongoing vignette found in the Community Connections sections of this chapter. The intent is not to provide a detailed and complex discussion of each theory, as there are numerous existing resources that serve this purpose. Rather, the intent is for the reader to recognize that many different theories and models exist, each of which should be identified and applied based on the overall need and goal associated with the health-related issue.

Intrapersonal Theories

The Health Belief Model

The Health Belief Model (HBM), as its title suggests, has to do with beliefs surrounding health and was one of the first designed to encourage people to take action toward positive health.[3] The model emphasizes the role of perceptions of

vulnerability to an illness or condition and the potential effectiveness in treatment or action. It means health education specialists should take into consideration an individual's perception that they are vulnerable to a negative health condition and the actions on the part of individuals that could prevent the threat and eliminate possible illness or negative condition.

ⓘ DID YOU KNOW?

The first theoretical model designed for health education was the Health Belief Model, developed in the 1950s by a group of social psychologists at the U.S. Public Health Service.

COMMUNITY CONNECTIONS 1.2

© LWA/Dann Tardif/Blend Images/Getty

One of the health education programs Nadia was concerned about was motivating low-income mothers to immunize their infants for COVID-19. The method she used was direct communication through a brochure she developed and distributed to mothers who were clients participating in WIC. Nadia decided to apply the Health Belief Model because she knew it addresses a belief in perceived severity of illness and that, if informed of this severity, people would respond to prevention messages. The perception that their babies were at risk would surely motivate mothers to have their children immunized.

When the results of Nadia's efforts were 40% less than the program's goal, she turned to Jacque and asked for help. In analyzing the plan, Jacque assured Nadia that the choice of method was appropriate, the group identified was at high risk, and Nadia's goals and objectives, along with her evaluation methods, were reasonable. The problem was in implementing the theoretical model. Jacque could clearly see that the Health Belief Model, as used, was incomplete. In her explanations to Nadia, she pointed out that she only used one of the four principles of the model, which was to inform mothers of the potential severity associated with their infants not being COVID-19 immunized. After realizing the mistake of not implementing all the components of the model, Nadia asked Jacque how the model should have been applied to this situation.

Jacque explained that the program overemphasized the perceived severity associated with not protecting infants. What was missing was the perception of why and how children were susceptible to COVID-19. Another mistake was the failure to anticipate barriers that would discourage mothers from having their infants COVID-19 immunized. These might include cost, perceived threat to the infant's health if immunized, religious beliefs, and accessibility to services. The third, and probably most serious, mistake was neglecting the questions of what, where, when, and how services could be obtained. Nadia did not anticipate barriers and failed to plan services around the difficulties these barriers created. For example, she failed to make clear what the cost would be, who would qualify for free services, when infants should be immunized, the low risk of possible reactions, and where mothers could take their children to be immunized.

Jacque suggested that Nadia conduct a random sample of the priority population to determine if they had their children immunized and, if not, why. The results confirmed Jacque's assumptions. Nadia found that 65% of mothers did not have their babies immunized because of a perceived threat to the child's health, inconvenience, lack of time, and not knowing where they could receive services. Nadia realized that if the Health Belief Model had been fully applied to the methods she chose, more information would have been conveyed that may have addressed these perceptions.

The HBM is based on the belief that health-related behavior is determined by whether individuals (1) perceive themselves to be susceptible to a health problem, (2) see the health problem as serious, (3) are convinced they will benefit from treatment or prevention activities, and (4) recognize the need to take action and any barriers that would interfere with this action. Four questions dictate whether a person is convinced that actions taken are likely to prevent negative health conditions:

- Am I susceptible?
- Is it serious?
- Do the benefits in taking action overcome the emotional, financial, social, or other costs?
- Are services or help available?

The perceived need to take action is influenced by variables that affect a person's perceptions and, as a result, indirectly influence health behavior. These modifying factors include level of educational attainment, cultural differences, demographic characteristics, personal experiences, economic status, and other social determinants, all of which can influence the perception of susceptibility, severity, benefits, and barriers.

Theory of Planned Behavior

The Theory of Planned Behavior is based on the assumption that behavior, or the intention to behave in a certain way, is determined by the person's attitude toward the behavior, subjective norms, and perceived behavioral control. In other words, if a person perceives that a given outcome will be a positive experience, that others positively view it, and that it is not difficult to perform, the person is more likely to exhibit that behavior.[4]

The health education specialist needs to identify what a person's intention is regarding performing a prescribed behavior. This could be accomplished by identifying (1) attitudes toward the behavior—why they wish to perform the behavior and what expectations, both positive and negative, are held regarding the behavior; (2) subjective norms—what significant others will think about the behavior; and (3) perceived behavioral control—how difficult it will be for the individual to perform and maintain the behavior. If an inventory of the person's intentions is positive, it is more likely they will perform the intended behavior. Key to this theory is the concept of reasoned action. A person needs to reason, or think

COMMUNITY CONNECTIONS 1.3

Nadia had received a request from a local church to talk to a group of teenage girls about postponing sexual intercourse. Knowing peers often influence teens, she looked for an approach that would use positive influence as a motivator. Nadia knew the Theory of Planned Behavior focused on identifying behavioral intent and so decided that could be the foundation for her presentation.

Nadia asked the girls questions in order to clarify the level of intent the girls had to perform the desired behavior. Specifically, Nadia asked about attitudes regarding this behavior, whom they admired and respected, and what they would expect those they admired to do in the same situation. What she discovered, much to her delight, was that the girls' intentions to postpone sexual intercourse were generally positive. The questions Nadia asked really worked in helping the girls define the importance of the desired behavior and in identifying who might have difficulty in performing the behavior. She felt that if these girls identified significant others and thought about what they would do under similar circumstances, it would help them think twice and reconsider their actions. Nadia was pleased, as the use of the theory seemed to work. As she mentioned to Jacque, "I think I really made a difference." Jacque was also pleased with Nadia's success but reminded her that the Theory of Planned Behavior is a predictor of behavior. A lot of variables, such as self-efficacy, self-esteem, and communication skills, will determine if the girls' intentions will result in the desired behavior. From this, methods can be designed for these individuals based on theories related to the variables.

logically, about an intended behavior. This is a cognitive process—discovering or finding reasons or intentions to behave in a certain way.

Transtheoretical Model (Stages of Change)

The Transtheoretical Model is based on the assumption that behavior change is a process and individuals are at varying levels of motivation or readiness to change. People at different stages in the process of change can benefit from different interventions. In other words, the methods used for a desired outcome are not generic because individuals are not always at the same stage or level of readiness to change. The model also assumes that people may relapse or return to a previous stage, which can often happen. The model identifies five stages, or levels, of readiness that could be applied to any type of behavior change.[5]

- **Precontemplation**. Those in this stage have either no interest or no capability to initiate change. This could be due to lack of knowledge, previous failures at change, or other barriers that make it difficult to consider behavior change (e.g., lack of any understanding of the impact of calories associated with pizza and fast foods).
- **Contemplation**. These individuals are considering changing behavior someday but just not yet ready due to one or more barriers that prevent initiating the behavior. These barriers can include time, social support, money, fear, and many other difficult to overcome issues (e.g., desire to change eating habits but do not have support from family).
- **Preparation**. This stage includes individuals who are preparing for and experimenting with behavior change but lacking self-efficacy to actively engage in the process (e.g., setting a New Year's resolution or "next Monday" to begin eating healthier).
- **Action**. Individuals who are actively engaging in the behavior change process but having done so for less than a given period time needed to turn the action into a habit fit this stage of readiness change (e.g., following a 21-day healthy eating program).
- **Maintenance**. Those who have made change and are sustaining the behavior change over time are considered to be in maintenance (e.g., having followed healthy eating guidelines for the past year).

The model should be easy to remember because the key word *stage* is what the model encompasses; individuals move through many stages in their attempt to change behaviors. Because the theory is based on stages, it is necessary to determine the stage in which an individual or group resides. This is important, as the intervention provided must match the stage of readiness to change. Asking a few simple questions, as demonstrated in Community Connections 1.4, can be one means of determining the appropriate stage.

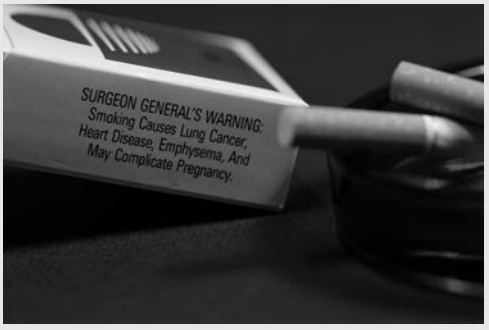
Ten processes of change, categorized as either cognitive and affective experiential processes or behavioral processes, are the mechanisms in which people engage in change.[5] Some processes, such as those focusing on getting the facts and noticing effects on others, are more akin to earlier stages of change, whereas those that focus on support systems, reinforcement, and managing the environment are more helpful with more active stages of readiness to change. Central to stages of change movement is the concept of decisional balance, focusing on the pros and cons associated with the change. As the pros start to outweigh the cons, the behavior is more likely to advance along the stage of change continuum.

? DID YOU KNOW?

According to its creators, James Prochaska and Carlo DiClemente, the Transtheoretical Model can also be used for addiction treatment and recovery.

Data from Fitzgerald, K. (2016, Nov. 1). 6 ways to understand the changes in addiction and treatment recovery. *The Recovery Village*. http://www.therecoveryvillage.com/recovery-blog/six-stages-change-recovery/

COMMUNITY CONNECTIONS 1.4



Courtesy of Debora Cartagena/CDC.

Max was given the responsibility of designing a smoking cessation program for employees of a small automotive parts manufacturing company. In taking on this task, he was concerned that some individuals would sign up for the program with different levels of readiness to change. For example, he assumed some had stopped smoking but, within a short period of time, started again. Some would have a support system of family and friends who would encourage their efforts. Others would be lifetime smokers who would find giving up smoking very difficult. Levels of readiness would range from a sincere desire to quit to a "been there, done that" attitude. Max needed to know the stage of change for each participant, but how? That was the question.

Max remembered that when he worked on a county tobacco policy coalition, the director of the community cancer agency had mentioned his experiences with smoking cessation programs. Max had been impressed with the materials from the cancer agency, and now he thought they might provide some helpful information. All it took was one email. The director shared stage-based questions that could be used to determine the stages of readiness to change associated with smoking behavior. What a find! Max's networking paid off, and his job was going to be much easier.

Max developed a questionnaire, based on examples provided by the director of the cancer agency, to determine the stages of participants' readiness. Questions focused on the following five stages of change:

- Interest in trying to quit
- Thinking about quitting soon
- Ready to plan a cessation attempt
- In the process of cessation
- Trying to stay smoke free

Max was able to arrange the participants into five groups according to their stage of readiness to engage in smoking cessation. As a result, different strategies and methods—such as personal testimonies, analysis of smoking behaviors and failed attempts, text messaging, determination and individualization of cessation approaches, use of online support systems, and use of medical personnel—were designed to help the participants implement changes over time.

Max felt good about applying the Transtheoretical Model in planning the smoking cessation program. He told Nadia, "I feel like I have individualized the approach in helping people give up a very unhealthy behavior."

Interpersonal and Community Theories

Social Cognitive Theory

Central to social learning theory is the belief that human behavior is explained in terms of a three-way, dynamic, and reciprocal phenomenon, in which personal factors, environmental influences, and behavior continually interact and influence each other. As such, a basic premise of Social Cognitive Theory (SCT) is that people learn not only through their own experiences but also by observing the actions of others and the results of those actions.[6] This theory is one of the most widely used among health education specialists to both describe human behavior and develop interventions for positively impacting change. Although at first SCT seems easily understandable, the theory is actually rather complex. The scenario in

COMMUNITY CONNECTIONS 1.5

Frustrated with the failure of individuals who signed up for their healthy eating and exercise program to change, Max considered talking with a health psychologist who specialized in behavior change. Max had previously met Dr. Parr, a nationally respected health education consultant who specializes in counseling clients with undesirable health behaviors. Max decided to call him to see if he could help him out. After a brief video conference with Dr. Parr, Max was enlightened regarding the potential of applying Social Cognitive Theory to his attempt to help participants with healthy eating and exercise behaviors. Dr. Parr had warned him, though, "Changing behavior is not easy because everyone comes from different environments and experiences. If, however, you apply program objectives and methods to theory, you will have a better chance of success."

Community Connections 1.5 can be used to apply six concepts essential to understanding SCT:

- **Reciprocal determinism** means behavior changes are determined from interactions between a person and their environment. The environment can influence or discourage a person in a healthy way or can be detrimental, depending on whether the environment is supportive or corrosive. Conversely, people can influence the environment so that it is more conducive to a healthy lifestyle. For example, some of the individuals in Max's program may experience environmental factors that are supportive of healthy eating and exercise, while others may not. If negative forces exist, it may be necessary to change the environment to provide opportunities for choosing healthy foods and for engaging in exercising. Max applied this concept by having each participant identify positive and negative forces in their work and living environments that helped or hindered their desire to lose weight.
- **Behavioral capability** is a person's capability to change a behavior by having the knowledge and skills necessary to enact a desired behavior. Applied to Max's program, it means that education is necessary to learn about healthy foods and their preparation as well as about types of exercises designed for flexibility, body tone, strength, cardiovascular fitness, and endurance. Skills also need to be developed, such as analyzing labels, counting calories, preparing food, taking one's target heart rate, lifting weights safely, and planning exercises for body tone and flexibility.
- **Expectations** include what a person expects as a result of modifying behavior. This is usually referred to as the positive value of the desired behavior. For Max's program, this would include expectations of improved physical appearance, becoming more physically fit, having more energy, and being more disciplined. These expected outcomes must counter the pleasures that come from poor choices such as eating foods that taste good but are unhealthy or avoiding the pain of exercise by not exercising. This is especially true early in a program before a person experiences results or the value of their predetermined expectations. Personal goals that are accomplished become rewards and are considered pleasurable. In attempting to help participants identify their expectations, Max, in the beginning, asked them to list their expectations as a result of losing weight and becoming more fit. These could then be developed into their personal goals.
- **Reinforcement** is the response to a person's behavior that will increase the continuance of the behavior. Positive reinforcement would be experienced in how individuals feel about the way they look and feel. The reinforcement of their expectations motivates them to continue with the program. External reinforcement methods used by Max were praise, before-and-after photos, and rewards.
- **Self-efficacy** can be defined as believing that one has the ability to take action and persist.

Accomplishing obtainable goals establishes a person's degree of efficacy. People who fail to accomplish predetermined goals become part of the history of failed attempts, causing self-defeating behavior. Max attempted to build efficacy by identifying and sharing personal strengths of the participants. Strengths such as perseverance, positive attitude, and a willingness to learn can go a long way in building self-efficacy.

- **Observational learning** includes the ability to learn by observing others. In so doing, a person can see success as well as failure and the positive or negative effects of these results. In Max's program, those who had been successful in both losing weight and maintaining weight loss provided personal testimonies, which Max chose to use as positive examples for his participants. Leaders need to serve as role models so they do not cause participants to think, "I can't hear what you say because of what I see."

Diffusion of Innovation

Diffusion of Innovation is a community-level change, versus intrapersonal or interpersonal change, theory that provides a process for disseminating and implementing innovations. The word *diffusion* means to integrate, distribute, or spread widely. *Innovation* is something that is new or different. Applied to health education, diffusion of innovation means integrating innovative ideas, products, or best practice programs into health education initiatives.

? DID YOU KNOW?

The tobacco industry has used Diffusion of Innovation Theory to promote flavored cigarettes to youth, as it attempts to stay ahead of public health practitioners by finding new tobacco users.

Data from Greenberg, M. R. (2006). The diffusion of public health innovations. *American Journal of Public Health*, 96(2), 209–210. http://doi.org/10.2105/AJPH.2005.078360

As new programs and materials are developed, innovative ideas and methods become available that improve the delivery of health education. Health education specialists need to keep abreast of new developments and apply them when appropriate. The question is how to select the best innovations and diffuse, or integrate, them into program implementation. Diffusion of Innovation incorporates established criteria for selecting innovations, which include the following:

- **Relative advantage** is the degree to which an innovation is seen as better than the idea, practice, program, or product it replaces.
- **Compatibility** refers to how consistent the innovation is with the values, habits, experiences, and needs of potential adopters.
- **Complexity** refers to how difficult the innovation is to understand or use.
- **Treatability** is the extent to which the innovation can be experimented with before a commitment to adopt it is required.
- **Observability** is the extent to which the innovation provides tangible or visible results.

Diffusion of Innovation also explains people's readiness to accept an innovation once they buy into it. Individuals accepting an innovation are known as *adopters* and can be characterized as follows:[7]

- **Innovators** are the first to adopt.
- **Early adopters** are interested but do not want to be the first to adopt.
- **Early majority adopters** accept innovations once others they respect have done so.
- **Late majority adopters** include individuals who are skeptical and late to adopt.
- **Late adopters (laggards)** are the last to get involved if they get involved at all.

Understanding the readiness of adopters is the key to selecting the best method for motivating individuals to subscribe to a new idea, product, or program. The early adopters and early and late majority, who, combined, are the largest group, will need to be convinced that the idea, product, or program would be to their advantage. It is up to

COMMUNITY CONNECTIONS 1.6

One of Max's initiatives for the year was to work with local public schools on a violence prevention program. This was the result of a needs assessment compiled by a county commission on violence that indicated a 35% increase in school violence over the past five years. The most common acts identified by the assessment were bullying, fighting, and threatening violence with intent to do harm.

Max was committed to the task and looked forward to the challenge. The problem was where to start. Should he develop a violence prevention curriculum with teacher training, or should he work with schools in developing school policy? To what extent should law enforcement agencies and the county prosecutor be involved? After using a program planning model and establishing goals and objectives, Max thought a curriculum with teacher training was the best approach. When he approached Jacque with his idea, she suggested he take a look at what evidence-based approaches already existed, as reinventing the wheel by developing new programs was not the best use of time and resources. Having had experience in disseminating the adoption of parent–child feeding policies among various WIC clinics in the state, she shared with Max that the most cost-effective approach that had the greatest potential for success was based on a theory that provides guidance in taking different innovations and diffusing them into program needs.

Max contacted state and national offices on violence prevention, reviewed curricula and school bullying programs, surveyed the literature, and talked to school administrators, law enforcement personnel, parents, and students. In addition, he took part in a webcast sponsored by the state Department of Education on violence and bullying prevention. Max had gathered a great deal of information, but the problem was how to select a curriculum that would most likely be adopted by the schools within the county. Having identified bullying, fighting, and threatening violence as the problems to be addressed and establishing related goals and objectives, he had to determine what approach, along with what methods and materials, to use.

Max chose the Diffusion of Innovation Theory to help them with this task. In so doing, he applied the five criteria designed to select the best innovation. In particular, he identified what the schools were presently doing (relative advantage), used a focus group to determine the innovation's compatibility with schools and its degree of difficulty to use (compatibility and complexity), and conducted a pilot test to determine extent of experimentation before it was adopted and to see if there were tangible results (treatability and observability). He next looked at the characteristics of adopters to determine what to expect from administrators regarding their readiness to adopt or buy into the program. He planned the marketing approach, selecting methods and strategies addressing each level of adopter.

the health education specialist to determine what methods and strategies can be used to communicate the innovation to the priority population, considering use of opinion leaders, media and social media channels, health communication campaigns, and other techniques described in this book.

Conclusion

This chapter presented a brief introduction to concepts and theories applicable to public health education methods. Health education theory is still in a stage of development and borrows from already established behavior change theories. Health education specialists need to stay abreast of new theories as they evolve and how they tie into the selection of intervention methods. At the same time, health education specialists need to ensure that the methods they are applying are relevant to the problems at hand and focus on impacting the priority population's key determinants of health from a social ecological, rather than only an individual, perspective.

Key Terms

Action Stage of readiness to change in which an individual is actively engaging in behavior change.
Behavioral capability The capability of an individual to change a behavior by having the knowledge and skills necessary to enact a desired behavior.
Compatibility How consistent an innovation is with the values, habits, experiences, and needs of potential adopters.
Complexity How difficult an innovation is to understand.
Contemplation Stage of readiness to change in which an individual may consider changing a behavior.
Early adopters Individuals interested in adopting an innovation but who do not want to be the first to do so.
Early majority adopters Individuals who accept innovations once others they respect have done so.
Expectation What is expected as a result of modifying a behavior.
Innovators The first individuals to adopt an innovation.
Late adopters (laggards) The last individuals to get involved, if at all, in adopting an innovation.
Late majority adopters Individuals who are skeptical and late to adopt an innovation.
Maintenance Stage of readiness to change in which an individual has been sustaining the behavior change over time.
Observability The extent to which the innovation provides tangible or visible results.
Observational learning The ability to learn by observing others.
Precontemplation Stage of readiness to change in which an individual is not interested in changing behavior.
Preparation Stage of readiness to change in which an individual is ready to change behavior but lacks the self-efficacy to do so.
Reciprocal determinism The theory that behavior changes are determined by interactions between a person and his or her environment.
Reinforcement The response to an individual's behavior that will increase the continuance of the behavior.
Relative advantage The degree to which an innovation is seen as better than the idea, practice, program, or product it replaces.
Self-efficacy Believing that one has the ability to take action.
Theory Knowledge, assumptions, or a set of rules or principles for the study or practice of a discipline.
Treatability The extent to which an innovation can be experimented with before a commitment to adopt it is required.

References

1. McLeroy, K. R., Steckler, A., & Bibeau, D. (1988). The social ecology of health promotion interventions. *Health Education Quarterly, 15*(4), 351–377. https://doi.org/10.1177/109019818801500401
2. Cottrell, R., Girvan, J., & McKenzie, J. (2018). *Principles and foundations of health promotion and education* (7th ed.). Benjamin Cummings.
3. Rosenstock, I. M. (1966). Why people use health services. *Milbank Quarterly, 44,* 94–124. https://doi.org/10.1111%2Fj.1468-0009.2005.00425.x
4. Ajzen, I. (1988). *Attitudes, personality, and behavior*. Dorsey Press.
5. Prochaska, J. O. (1979). *Systems of psychotherapy: A transtheoretical process*. Dorsey Press.
6. Bandura, A. (1977). *Social learning theory*. Prentice-Hall.
7. Rogers, E. M. (1983). *Diffusion of innovation* (3rd ed.). Free Press.

Practical Application Items

1. Janell is a health education specialist who is developing a risk reduction unit for a sexual health education program. She has selected all the methods to reach her presentation objectives. When you ask her what theory is serving as the framework for the program, she states that she doesn't need one as these methods will work to meet her goals and objectives. What would you say to Janell about the role of theory in program development?
2. If a health education specialist was using the Health Belief Model as a framework for a vaping prevention programming with high school students, what might be three objectives grounded in this theory that would help keep teens from vaping? What might be a theoretically based method/activity to meet each of the three objectives?
3. The HESPA II 2020 Areas of Responsibility, Competencies, and Sub-competencies for Health Education Specialists only includes one direct sub-competency related to theories. Do you think that is sufficient, or would you suggest other sub-competencies be developed in the next revision?